UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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JOANNA TULCZYNSKA,

Plaintiff,

17 Civ. 1669 (DAB)
MEMORANDUM & ORDER

v.

QUEENS HOSPITAL CENTER, et al.,

Defendants.

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DEBORAH A. BATTS, United States District Judge.

On February 7, 2017, Plaintiff Joanna Tulczynska filed suit in New York County Supreme Court against Defendants Queens Hospital Center ("QHC"), Mount Sinai Health System, Inc. ("Mount Sinai") (together, the "Hospital Defendants"), and Prudential Insurance Company of America ("Prudential") for unilateral mistake (Count I), negligence (Count II), constructive fraud (Count III), and misrepresentation (Count IV); against the Hospital Defendants and Defendant Dr. Ricardo Lopez for discrimination in violation of the Fourteenth Amendment of the United States Constitution, the Americans with Disabilities Act ("ADA"), the New York State Constitution, and the New York State Human Rights Law ("NYSHRL") (Count V); and against the Hospital Defendants as well as Lopez, Defendant Dr. Jean Fleishman, and Dr. Habibur Rahman (collectively, the "Individual Defendants") for wrongful termination in violation of the U.S. Constitution, the ADA, the New York Constitution, and NYSHRL (Count VI) and

personal injury due to discrimination under the U.S. Constitution, the ADA, the New York Constitution, and NYSHRL (Count VII).[1]

The Hospital and Individual Defendants removed the case to this Court on March 6, 2017 and filed a Motion to Dismiss on March 13, 2017, which Plaintiff opposed. Prudential filed its own Motion to Dismiss on April 17, 2017,[2] which Plaintiff also opposed. On May 17, 2017, Plaintiff filed a Motion seeking to remand her case back to State Court, amend her Complaint, and file a late notice of claim, which all Defendants opposed. For the following reasons, the Court GRANT Defendants' Motions to Dismiss.

I. BACKGROUND

A. Disability Insurance

Plaintiff worked for QHC as a pulmonologist and as an associate professor at Mt. Sinai School of Medicine. (Compl. ¶ 2.)[3] While employed at QHC, Plaintiff went to its Human Resources

[1] In various Memoranda of Law under consideration by the Court, Plaintiff also cites the New York City Human Rights Law ("NYCHRL") as a basis for her disability discrimination claims, but the Complaint contains no references to the NYCHRL.

[2] Due to a docketing error, Prudential refiled its Motion on May 26, 2017.

[3] Plaintiff's Complaint includes virtually no dates.

department, run by Roselyn Marquez,[4] seeking to enroll in a disability insurance policy, administered by Prudential, under which Plaintiff would pay the premiums with post-tax dollars so that she could avoid paying taxes on any benefits she might later receive from the policy. (Id. ¶ 11.) However, QHC's Human Resources department, Mt. Sinai, and Prudential, allegedly contrary to their promises, enrolled Plaintiff in a plan under which Plaintiff paid premiums with pre-tax dollars. (Id. ¶ 12.) Plaintiff became aware of QHC, Mt. Sinai, and Prudential's alleged mistakes when the Internal Revenue Service informed her that she owed $28,284.32 in back taxes. (Id. ¶ 13.)

B. Disability Discrimination

Plaintiff has Parkinson's Disease, which QHC and Mt. Sinai have been aware of since 1996. (Compl. ¶ 32.) She alleges that Ricardo Lopez, QHC's Chief Pulmonologist, told her, at least twice, that she would not receive a workplace accommodation for her Parkinson's Disease nor would she receive any special treatment because of it. (Id.) Plaintiff alleges that, because of the Hospital Defendants' refusal to provide her with an

[4] Although Marquez is included in the caption of this case and is specifically mentioned in Count I, it is unclear whether Plaintiff actually seeks to hold Marquez personally liable. For simplicity's sake, the Court does not include her in its discussion of Counts I through IV. However, the Court's ruling also applies to any attempts by Plaintiff to make out causes of action against Marquez.

accommodation, she was forced to retire early, thereby constituting constructive discharge due to her disability. (Id. ¶ 38.) Plaintiff also alleges that Habibur Rahman, another doctor in QHC's pulmonology department, Jean Fleishman, another then-Chief Pulmonologist and administrator at QHC, and Lopez made derogatory marks about her. (Id. ¶ 38.) For example, when Plaintiff was in line for a Chief of Pulmonary position, Rahman said, "We will not work for you." (Id.) Based on the rules of promotion for the Hospital Defendants, Plaintiff was allegedly in line for the position of Chief of Pulmonology, but Fleishman passed her over for the position in favor of Lopez. (Id.) All of this allegedly served to aggravate Plaintiff's condition. (Id. ¶ 43.)

II. Discussion

A. Legal Standard for Motion to Dismiss

For a complaint to survive a motion brought pursuant to Federal Rule of Civil Procedure 12(b)(6), the plaintiff must have pleaded "enough facts to state a claim to relief that is plausible on its face." Bell Atl. Corp. v. Twombly, 550 U.S. 544, 570 (2007). The Supreme Court has explained,

> A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged. The plausibility standard is not akin to a "probability requirement," but it asks for more than a sheer possibility that a defendant has acted

> unlawfully. Where a complaint pleads facts that are "merely consistent with" a defendant's liability, it "stops short of the line between possibility and plausibility of entitlement to relief."

Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009) (quoting Twombly, 550 U.S. at 556–57). "[A] plaintiff's obligation to provide the grounds of his entitlement to relief requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." Twombly, 550 U.S. at 555 (internal quotation marks and citation omitted). "Nor does a complaint suffice if it tenders 'naked assertion[s]' devoid of 'further factual enhancement.'" Iqbal, 556 U.S. at 678 (quoting Twombly, 550 U.S. at 557). The Supreme Court further stated,

> In keeping with these principles a court considering a motion to dismiss can choose to begin by identifying pleadings that, because they are no more than conclusions, are not entitled to the assumption of truth. While legal conclusions can provide the framework of a complaint, they must be supported by factual allegations. When there are well-pleaded factual allegations, a court should assume their veracity and then determine whether they plausibly give rise to an entitlement to relief.

Id. at 679.

In considering a Rule 12(b)(6) motion, the Court must accept as true all factual allegations set forth in the complaint and draw all reasonable inferences in favor of the plaintiff. See Swierkiewicz v. Sorema N.A., 534 U.S. 506, 508 (2002); Blue Tree Hotels Inv. (Canada) Ltd. v. Starwood Hotels & Resorts Worldwide, Inc., 369 F.3d 212, 217 (2d Cir. 2004).

However, this principle is "inapplicable to legal conclusions," Iqbal, 556 U.S. at 678, which, like the complaint's "labels and conclusions," Twombly, 550 U.S. at 555, are disregarded. Nor should a court "accept [as] true a legal conclusion couched as a factual allegation." Id. at 555. In resolving a 12(b)(6) motion, a district court may consider the facts alleged in the complaint, documents attached to the complaint as exhibits, and documents incorporated by reference in the complaint. DiFolco v. MSNBC Cable L.L.C., 622 F.3d 104, 111 (2d Cir. 2010).

B. Whether Federal Jurisdiction Exists and Whether Counts I through IV Are Preempted by ERISA

Plaintiff's disability discrimination claims raise federal questions on their face, citing violations of the Americans with Disabilities Act and the U.S. Constitution. Plaintiff, however, has consented to withdraw these claims and seeks to remand the case back to State Court.

In general, "[t]he 'well-pleaded complaint rule' is the basic principle marking the boundaries of the federal question jurisdiction of the federal district courts." Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 63 (1987). Ordinarily, federal preemption is a defense and, accordingly, does not appear on the face of a complaint. Id. There is an exception, however, to the well-pleaded complaint rule when Congress "so completely pre-empt[s] a particular area that any civil complaint raising this

select group of claims is necessarily federal in character." Id. at 63-64. The Supreme Court has held that this exception applies to cases involving plans covered by ERISA § 502(a). Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 53-57 (1987); Metro. Life Ins. Co. v. Taylor, 481 U.S. at 64-67; Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004).

In general, "preemption depends on whether state remedies are consistent with ERISA's core purposes." Gerosa v. Savasta & Co., 329 F.3d 317, 325 (2d Cir. 2003). The Second Circuit characterized the preemption test in Arditi v. Lighthouse International, 676 F.3d 294, 299 (2d Cir. 2012), as amended (Mar. 9, 2012):

> Under the Supreme Court's test in [Aetna Health Inc. v.] Davila[, 542 U.S. 200 (2004)], ERISA preempts a cause of action where: (1) "an individual, at some point in time, could have brought his or her claim under ERISA § 502(a)(1)(B);" and (2) "no other independent legal duty . . . is implicated by a defendant's actions." To avoid potential confusion under the first prong of Davila, this Court has further clarified that the plaintiff must show that: (a) he is the type of party who can bring a claim pursuant to § 502(a)(1)(B) of ERISA; and (b) the actual claim asserted can be construed as a colorable claim for benefits pursuant to § 502(a)(1)(B).

Id. at 299 (internal citations omitted). In terms of types of parties who can bring claims under ERISA, cases involving "core ERISA entities: beneficiaries, participants, administrators, employers, trustees and other fiduciaries, and the plan itself" are likely to be preempted, while those that do not involve core

entities are not likely to be preempted. Gerosa, 329 F.3d at 324.

"[S]tate laws that would tend to control or supersede central ERISA functions-such as state laws affecting the determination of eligibility for benefits, amounts of benefits, or means of securing unpaid benefits-have typically been found to be preempted." Id. Courts in this Circuit have, at times, held that claims under New York State law for breach of contract, breach of common-law fiduciary duty, fraud, negligence, and misrepresentation are preempted by ERISA. Varela v. Barnum Fin. Grp., 644 F. App'x 30, 31-32 (2d Cir. 2016); Costa v. Astoria Fed. Sav. & Loan Ass'n, 995 F. Supp. 2d 146, 154-55 (E.D.N.Y. 2014) (collecting cases). However, the Second Circuit has noted "garden-variety state-law malpractice or negligence claims against non-fiduciary plan advisors, such as accountants, attorneys, and consultants" as types of claims not likely to be preempted. Id. Similarly, claims arising from promises made separately from an ERISA plan that do not affect the terms of the plan are not preempted by ERISA. Stevenson v. Bank of N.Y. Co., 609 F.3d 56, 62 (2d Cir. 2010).

1. Application to Counts I through IV

Plaintiff argues that her claims do not arise from the benefit itself, but rather from a separate promise to enroll her

in an after-tax disability policy and the Hospital Defendants' and Prudential's failure to do so. (Pl.'s Mem. Law Supp. Mot. to Remand at 7.) She says her claims are based not on a wrongful denial of benefits under the plan she was enrolled in, but instead that she was enrolled in the wrong plan altogether. (Id.)

Plaintiff's arguments fail. Plaintiff does not dispute that the plan she was enrolled in is an ERISA-governed plan. Although she can twist her claims to say that she was enrolled in the wrong plan, under the first prong of the Davila test, she also could have brought her claims pursuant to ERISA. For example, she could instead say that the Hospital Defendants and Prudential falsely represented to her the terms of the plan in which she was enrolled. While ERISA preemption is not without limits, the game of semantics Plaintiff's construction would require the Court to engage in to hold her claims were not preempted runs into ERISA's broad scheme and its purpose of creating uniform enforcement mechanisms.

Under the second prong of the Davila test, Prudential and the Hospital Defendants did not owe Plaintiff a fiduciary duty separate from any duty owed by them under ERISA. Plaintiff's Complaint states that they owed her a duty based on the fact that she signed up for a disability insurance policy. (Compl. ¶ 14.) It is unclear to the Court how this creates a duty outside

of those in the referenced ERISA plan or in the statute itself. This is evident when Plaintiff's case is compared to cases such as Gerosa v. Savasta & Co., 329 F.3d 317 (2d Cir. 2003). In Gerosa, the plaintiffs brought a claim, among others, for professional malpractice against a plan actuary. The Court noted that "[r]egulating the professions, particularly under a rubric of professional malpractice, is a traditional state function." Id. at 328. Here, Plaintiff does not cite any state law in support of her claims nor offer any other explanation for why the Hospital Defendants and/or Prudential owe her a duty.

Furthermore, Plaintiff, the Hospital Defendants, and Prudential are "core ERISA entities." See id. at 324. Plaintiff is a beneficiary/participant in the plan, the Hospital Defendants are employers, and Prudential is the plan's administrator.

Plaintiff's case can be distinguished from Stevenson v. Bank of New York Co., 609 F.3d 56 (2d Cir. 2010), on which she relies. Unlike in Stevenson, Plaintiff here was still a beneficiary of the plan, whereas Stevenson came to a separate agreement with the defendants in that case precisely because he left the defendant's employ and was no longer participating in the plan. See id. at 60-61; Arditi, 676 F.3d at 300.

Furthermore, that Plaintiff's claims are preempted by ERISA is also evident when looking at the language of her Complaint.

Under Count I, unilateral mistake, Plaintiff pleads that she entered a contract with the Hospital Defendants and Prudential, requiring them to act as her fiduciary, when she "asked to sign up for a disability policy and that policy was signed." (Compl. ¶ 14.) Further, they allegedly breached this duty by paying her premiums with pre-tax rather than post-tax dollars. (Id.) By Plaintiff's own words, the duty owed to her arises from the signing of the policy, or in other words the ERISA plan. This is not a separate duty owed to Plaintiff or a separate contract. See Arditi, 676 F.3d at 299; Stevenson, 609 F.3d at 62. In addition to the duty implicated, the breach itself arises from the plan: the money Plaintiff paid according the purportedly misrepresented plan. Count II, negligence, is preempted for the same reasons (see Compl. ¶ 19 (stating that Hospital Defendants and Prudential owed Plaintiff a duty by virtue of entering a contractual relationship with her when she signed up for disability insurance)), as are Count III, constructive fraud (see id. ¶ 23 ("The Three Defendants had a fiduciary relationship with the Plaintiff by the Three Defendants controlling the creation, management, and payment of the premiums of Plaintiff's disability insurance policy.")) and Count IV, misrepresentation. (See id. ¶ 27 ("The Three Defendants made a misrepresentation to Plaintiff that they would create, manage, and collect premiums for this policy in the way

and manner than the Plaintiff wished."); Varela, 644 F. App'x at 31.).

Counts I through IV thus all arise directly from the ERISA-governed plan Plaintiff, a core ERISA entity, entered into with the Hospital Defendants and Prudential, also core ERISA entities. Therefore, they are preempted by ERISA and DISMISSED with prejudice under Rule 12(b)(6). See Costa, 995 F. Supp. 2d at 155 (dismissing state law claims preempted by ERISA with prejudice).

C. Leave to Amend

Plaintiff has withdrawn her claims under the ADA and the United States Constitution, and the Court has dismissed the remaining causes of action over which it has subject matter jurisdiction. The remaining questions are whether Plaintiff shall be given leave to replead the claims implicating ERISA and how to address the remaining State law causes of action related to disability discrimination. When a complaint has been dismissed, "[t]he court should freely give leave [to amend] when justice so requires." Fed. R. Civ. P. 15(a)(2). However, a court may dismiss without leave to amend when amendment would be "futile," or would not survive a motion to dismiss. Hutchison v. Deutsche Bank Sec. Inc., 647 F.3d 479, 491 (2d Cir. 2011).

Here, Plaintiff is GRANTED leave to replead Counts I through IV as ERISA claims. See Enigma Mgmt. Corp. v. Multiplan, Inc., 994 F. Supp. 2d 290, 305 (E.D.N.Y. 2014). Assuming Plaintiff amends to give this Court federal jurisdiction, the pendant jurisdiction claims may also be amended should Plaintiff be able to cure the alleged insufficiency of those claims as well. Should Plaintiff decline to replead Counts I through IV as ERISA claims, the Court shall decline to exercise pendant jurisdiction over the remaining state claims. See Marcus v. AT&T Corp., 138 F.3d 46, 57 (2d Cir. 1998) ("In general, where the federal claims are dismissed before trial, the state claims should be dismissed as well."). The Court will then REMAND Counts V, VI, and VII to State Court.

Plaintiff shall notify the Court whether she intends to amend her Complaint. If Plaintiff decides to amend, she shall file an Amended Complaint within 45 days of the date of this Memorandum & Order. If she decides not to amend, she shall notify the Court of her decision within the same time period, at which point the Court will remand the state causes of action to State Court.

III. CONCLUSION

For the foregoing reasons, Defendants' Motions to Dismiss are GRANTED.

SO ORDERED.

DATED: New York, NY
March 14, 2018

Deborah A. Batts
United States District Judge